No. _____

In the
Supreme Court of the United States

RICHARD M. COWETT, M.D.
Petitioner,

v.

TCH PEDIATRICS, INC., et al.,
Respondents

On Petition for a Writ of Certiorari to the State of Ohio, Mahoning County Court of Appeals, Seventh District

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

The Health Care Quality Improvement Act of 1986 (HCQIA) grants limited immunity from damages to "professional review bodies" for "professional review actions" when those actions satisfy the Act's reasonableness and due process standards.

The Act's first reasonableness standard is that a peer review action "must be taken in the reasonable belief that the action was in the furtherance of quality health care." 42 U.S.C. § 11112 (a)(1).

The questions presented are:

1. Is evidence that peer review action was motivated by economic or political reasons, unrelated to the quality of patient care, relevant to determination of HCQIA immunity on motion for summary judgment?

2. Can HCQIA provide immunity, as a matter of law, for a "professional review action" taken in bad faith?

PARTIES TO THE PROCEEDING - Rule 14.1(b)

A list of all parties to the proceeding in the court whose judgment is the subject of this petition is as follows:

Plaintiff-Appellant-Petitioner:
Richard M. Cowett, M.D.

Defendants-Appellees-Respondents:
TCH Pediatrics, Inc.,
Tod Childrens Hospital,
Western Reserve Care System,
Forum Health

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The opinion of the Ohio Supreme Court is reported at 2/28/2007 Case Announcements, 2007-Ohio-724 (App, *infra*, 1a). The opinion of Ohio's Seventh District Court of Appeals is reported at 2006-Ohio-5269 (App, *infra*, 2a-18a). The opinions of the Mahoning County Court of Common Pleas are unreported but can be found, respectively, at 02 CV 3259, 7/13/2005 Judgment Entry (App, *infra*, 19a-22a) and 02 CV 3259, 4/4/2005 Judgment Entry (App, *infra*, 23a-25a).

JURISDICTION - Rule 14.1(e)

The judgment of the Ohio Supreme Court was entered on February 28, 2007. This Court's jurisdiction is invoked under 28 U.S.C. § 1257 and the United States Constitution, Article III, Sections 1 and 2.

STATUTE INVOLVED IN THE CASE - Rule 14.1(e)

This Petition involves the Health Care Quality Improvement Act at 42 U.S.C. §§ 11101, 11111, 11112 and 11151 (App, *infra*, 26a-41a).

STATEMENT

Petitioner, Richard Cowett, M.D., was hired in August of 2001, as Director of the Special Care Nursery (SCN) at Tod Childrens Hospital in Youngstown, Ohio. He was then renowned in his field, having published an internationally acclaimed treatise on neonatal metabolism and having taught and treated babies at prestigious institutions such as Brown University and the Cleveland Clinic. His 30-year medical career was unblemished by malpractice lawsuits or peer discipline.

Within two months of arriving at Tod, Dr. Cowett was terminated and branded in the National Practitioner Data Bank (NPDB) as an incompetent physician. He did not suddenly lose a lifetime's skill and ability upon coming to Youngstown. He was a victim of sham peer review.

Throughout the United States, there is growing public outcry over sham "peer review" discipline destroying the careers of skilled and honorable physicians. In recent years, major newspapers have written about "sham" and "retaliatory" hospital peer review against physicians. For example, in 2003, the Pittsburgh Post-Gazette explored the subject in a four-day series of articles.[1] Medical journals have editorialized about "Sham Peer Review and the Courts."[2] There are multiple national organizations devoted to publicizing peer review injustice.[3]

The matter is of national importance. Frequent abuse of hospital peer review for political or economic purposes

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[1] See Steve Twedt, *The Cost of Courage - Four Part Series*, PITTSBURGH POST-GAZETTE, October 26, 2003 - October 29, 2003, *available at* http://www.post-gazette.com/pg/03299/234499.stm (last visited May 23, 2007).

[2] Lawrence R. Huntoon, M.D., Ph.D., *Sham Peer Review and the Courts*, JOURNAL OF AMERICAN PHYSICIANS & SURGEONS, Volume 11, No. 1, Spring 2006, at 4-5, *available at* http://www.jpands.org//vol11no1/huntoon.pdf (last visited May 23, 2007).

[3] See, e.g., The Semmelweis Society International, http://www.semmelweis.org and http://www.Semmelweis Society.net (last visited May 23, 2007); American Association of Physicians & Surgeons, Inc., http://www.aapsonline.org (last visited May 23, 2007); The Center for Peer Review Related Justice, http://www.peerreview.org (last visited May 23, 2007).

threatens the quality of medicine, but increasingly goes unremedied and undeterred, because courts have transformed HCQIA's qualified immunity into a *de facto* absolute immunity.

Petitioner's case is illustrative. His medical skill and previously unblemished record cannot be questioned. The peer review that ended his career did not originate from true quality of care concerns. It happened because he became trapped between hospitals fighting over power and money.

Peer Review as Business Tool

When it hired Petitioner, Tod Childrens Hospital was pursuing an important business relationship with University Hospitals of Cleveland, Ohio (UH).[4] Tod had faced extreme difficulty recruiting and retaining physicians in Youngstown. It relied on UH to help staff certain Tod hospital units with UH physicians.

UH was willing to send physicians to Tod, because it was competing with the Cleveland Clinic Foundation to merge or affiliate with smaller hospitals statewide, in order to expand a "network" of hospitals and thereby increase its patient revenues.

The arrangement created tension between Tod and UH. Tod's Director of Pediatrics, Richard Felter, M.D., knew that UH would "probably" want more control over Tod units they staffed. But, Felter testified, "...that was never my intent." And UH's Chairman of Pediatrics, Ellis Avner, M.D., knew

[4] The related entities, University Hospitals, University Hospitals Health Systems and Rainbow Babies and Childrens Hospital of Cleveland, are collectively referenced herein as "UH."

that Felter and Tod feared that affiliation with UH would result in the loss of power and patients at Tod. Avner testified: "I think ...there was always the concern of the big center, you know, taking over the little center and transferring all the babies to [UH]."

If UH was to staff Tod units, it intended to control those units (primarily by appointing the head physician in the unit).[5] UH thought Tod had agreed, and thought the two hospitals would collaborate to decide who would be the director of Tod's SCN. Testimony established that UH was unhappily "surprised" to learn "after the fact" that Tod had hired Petitioner (who was not a UH faculty member) to head its SCN. Into this thorny situation stepped Petitioner, as Tod's new SCN Director.

When Petitioner arrived at Tod, Dr. Natalie Yeaney (a UH physician only weeks out of her residency), was assigned to Tod's SCN. Yeaney looked down on Petitioner because he was not on staff at UH ("...he wasn't hired by our division so he wasn't—we weren't the same."). At the same time, Dr. Felter noted that some Tod employees believed UH had placed Dr. Yeaney at Tod "just to feed kids up to their SCN [in Cleveland]...[and that] was getting everyone upset."

Immediately, Dr. Yeaney insubordinately challenged several of Petitioner's leadership and medical decisions. When she disagreed with his medical decisions, she consulted her mentors at UH and disregarded Petitioner, her boss. Within weeks, Yeaney presented three meritless complaints about Petitioner's treatment of certain babies. In another hospital, such complaints would routinely have been handled.

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[5] For example, UH already controlled Tod's pediatric intensive care unit (PICU), because a UH physician headed that unit.

But Tod's unit was polarized by the struggle for control. These complaints became the genesis of the "professional review action" that led to Petitioner losing his clinical privileges.

Tod's medical staff bylaws described a peer review process which began with a departmental investigation, proceeded to an evidentiary "Fair Hearing" before a panel of three physicians, and concluded with appellate-style reviews by different hospital administrative committees. Cumulative evidence established that the process was tainted from its outset. Perhaps most illustrative was an e-mail discovered in this litigation.

An October 18, 2001 e-mail, sent from UH's Dr. Avner to one of his physician subordinates, describes Avner's impressions of a videoconference meeting that day, wherein the heads of Tod and UH had discussed "the neonatology issues at Tod." Notably, this videoconference occurred weeks prior to the "Fair Hearing" where Petitioner could present evidence to defend against Yeaney's complaints. The e-mail stated Avner's observations and goals at Tod, in pertinent part, as follows:

> The ultimate goal is a PICU-like arrangement [a UH physician already headed the PICU at Tod] ... the key, as always, is the interim arrangement. *We will need to provide leadership from [UH]*, and build the neonatology group while supporting Natalie [Yeaney] and Ben... Interesting, Brenda Douglas has reappeared to do some moonlighting, and *may be ready to be re-approached as our leader at Tod*...in addition, there are some Neonatologists available because of some meltdown in Toledo, and [Tod] *is getting names/CVs of candidates*.

> ***I want you and your division in control and [Kristopher] Hoce [the CEO of Tod] will force Felter to cede to our wishes.*** Obviously, our *contract with Tod will need to reflect this control and pay for it.*
>
> Any of your faculty who work in any fashion at Tod *must talk-up the "alliance"*--we cannot create the spin that we are downgrading their nursery to simply transfer all sick newborns to Rainbow--this will cause a riot, and *Tod is VERY sensitive to anything that looks like a hostile takeover rather than a committed partnership.... We need to build this as your Division (and its quality) operating at Tod* in addition to the level 2's we are growing up as part of the system (emphasis supplied).

This e-mail (somehow unmentioned in the appellate court's discussion of this case) is potent evidence about what happened behind the scenes of Tod's peer review process. It shows that, weeks before Petitioner's "Fair Hearing," Tod and UH had already decided to replace Petitioner as "our leader at Tod." Further, it evidences that UH wanted its people "in control" of Tod's SCN; wanted to be paid for that control, and that Tod's CEO had indicated he would "force" Petitioner's superior, Dr. Felter (who was then directing the ongoing peer review process) to give them what they wanted.

To lawfully pacify UH, Tod could simply have advised Petitioner of its dilemma, terminated his contract and collaborated with UH to name his replacement. But Tod would then have owed Petitioner $400,000 under his employment contract. Instead, it pursued Dr. Yeaney's false charges through the peer review process, enabling it to terminate Petitioner's hospital privileges (thereby obviating Tod's obligations under the contract's terms). That act of bad

faith saved Tod $400,000--and ended Petitioner's medical career.

Buttressing this e-mail and its obvious implications was other cumulative evidence tending to rebut the presumption that Tod acted in the reasonable belief its action furthered quality healthcare.

For example, at the first (departmental investigation) phase of its professional review action against Petitioner, Dr. Felter assigned a reviewer, Kurt Wegner, M.D., to investigate. Dr. Wegner (a long-time Tod employee who had not recently been credentialed to practice neonatology or perform any of the procedures he was reviewing) investigated Yeaney's complaints against petitioner by selectively interviewing certain unit employees. He was required under medical staff bylaws to provide Petitioner an opportunity to "explain or refute" the charges against him. Yet, Wegner reached his opinion and wrote his conclusions in a report without interviewing Petitioner.

Indeed, when Felter and Wegner eventually provided Petitioner the required meeting to "explain or refute" the charges, Dr. Wegner began the meeting by handing Petitioner his written conclusions. And Dr. Felter conceded in deposition that his mind was already made up before this meeting.

Dr. Felter's departmental peer review report (which was later presented to every hospital committee that heard the case) contained inflammatory falsehoods. For example, it alleged that Petitioner "blew off" a surgeon's recommendation to perform surgery on one baby. But the surgeon never made such an allegation. Indeed, neither Felter nor Wegner ever spoke to the surgeon. The

misinformation was later attributed to hearsay Felter obtained when he talked to the surgeon's boss. When deposed in this case, the surgeon denied ever saying or feeling he had been "blown off."

The subsequent evidentiary "Fair Hearing" had the hallmarks of a show trial. Before it ever commenced, Tod ran an advertisement for Dr. Cowett's replacement in the SCN and UH obtained control of the unit, along the exact lines described in Dr. Avner's e-mail of October 18, 2001.

During the "Fair Hearing," Dr. Felter announced to the hearing panel that Petitioner would never return to work at Tod, regardless of what the panel's findings were.

Tod had never asked a practicing, board-certified neonatologist to review the disputed patient cases in question and did not present such expert testimony at the hearing (yet the panel disregarded the opinions of <u>two</u> such experts favoring Dr. Cowett). Instead, Dr. Wegner testified for the hospital. He admitted on cross examination that he was actually criticizing Dr. Cowett's "leadership" abilities and "philosophy" of practicing medicine. He conceded: *"I don't know anything about his skills."*

This (and much more) evidence potently suggested that Tod's professional review action was a sham--designed to pacify its business partner and avoid buying out Petitioner's employment contract, not to further quality health care.

Petitioner was terminated by the hospital and reported to the NPDB. Despite inquiring for employment at more than 20 hospitals across the East coast of the country, he has never again been able to work in patient care.

This litigation

Petitioner filed suit in Ohio state court in August of 2002, asserting numerous claims arising from the termination of his medical privileges at Tod. Defendants-Appellees pleaded the defense of HCQIA immunity.

During the case, in early 2004, Petitioner had begun to request and obtain discovery about Tod's business relationship with UH. In the midst of that discovery, the Defendants-Appellees filed a motion for summary judgment, moved simultaneously to stay all discovery and cancelled further scheduled discovery, concluding unilaterally that "sufficient discovery" had occurred. After a hearing, the trial court overruled the motion to stay discovery and Petitioner obtained substantial additional discovery, which was used in his Brief in Opposition to Motion for Summary Judgment.

In March of 2005, the trial court held a lengthy hearing with oral arguments on the Motion for Summary Judgment. On April 4, 2005, the trial court filed an order denying summary judgment, finding a genuine issue of material fact about the "reasonableness" of the peer review proceedings conducted.

However, on the eve of trial, Defendants-Appellees filed (along with a flurry of other motions and filings) a motion requesting reconsideration of the trial court's summary judgment ruling. On July 13, 2005--three working days before trial was to begin--the trial court abruptly reversed its earlier ruling and entered summary judgment.

Petitioner timely appealed the trial court's about-face ruling. Ohio's Seventh District Court of Appeals affirmed the trial court's ruling. The appellate court refused to consider

Petitioner's evidence that his discipline was motivated by the hospital's profit interests and not "in the reasonable belief that the action was in the furtherance of quality health care." The court applied state and federal court rulings that substitute for HCQIA's statutory language a judge-created "objective reasonableness" test for immunity. That test finds irrelevant any evidence of supposed bad faith, malice or animosity behind the challenged discipline. *Cowett v. TCH Pediatrics, Inc.*, 7th Dist. No. 05 MA 138, 2006-Ohio-5269, at ¶18 (Ohio App. 2006).

On February 28, 2007, Ohio's Supreme Court, by a 5-2 vote, declined to accept jurisdiction to hear the case.

REASONS FOR GRANTING THE PETITION

Courts deciding HCQIA immunity cases throughout the federal and state judicial systems repeatedly have applied a judge-made "objective test" that contradicts HCQIA's plain statutory language, as well as its legislative intent. This test has converted the statute's qualified immunity into a rule of virtually absolute immunity.

This test creates absurd results which could never have been contemplated by Congress. Under this test as applied, a statutory qualified immunity protects even "malicious" or "bad faith" actions, as a matter of law.

This Court has not resolved the questions presented herein but should do so, in order to bring clarity to this important area of the law, to enforce Congress' intent, and to discourage such judicial legislating.

A. Congress Enacts Limited Immunity From Damages

In 1986, the United States Congress passed the HCQIA, out of concern that incidents of medical malpractice were increasing and the nation's quality of medical care was declining. Physicians and hospitals attempting to address the quality of care issue claimed an inability to properly conduct "peer review" without some immunity from subsequent lawsuits by disciplined physicians. See H.R. REP. NO. 99-903, at 2-3 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6385, 1986 WL 31972 (also attached as Appendix I, at 43-46a to this Petition).

Yet, Congress feared that federal peer review immunity might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls. H.R. REP. NO. 99-903, at 9 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6391, 1986 WL 31972 (also attached as Appendix I, at 57a to this Petition). Physicians or hospitals seeking to silence a critic or competitor were known to invoke sham disciplinary proceedings against them. Such abuse was common and had resulted in much-publicized jury verdicts for physicians against hospitals, in the mid-1980's.

The limited immunity set forth in HCQIA was the compromise result.

The enacted scheme of statutory immunity is unambiguous. To qualify for HCQIA immunity, peer review actions must be taken:

(1) in the reasonable belief that the action was in the furtherance of quality health care;

(2) after a reasonable effort to obtain the facts of the matter;

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and,

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C. § 11112(a)(1)-(4).

A hospital must have complied with all four standards to be protected by HCQIA's qualified immunity.

The statute presumes that a challenged peer review action was reasonable. But a physician can rebut the presumption "by a preponderance of the evidence." 42 U.S.C. § 11112.

B. Courts Devise Their Own Test for Immunity

From the outset of HCQIA litigation, certain federal courts broadened the statute's limited immunity beyond the parameters clearly described by Congress. Decisions from these courts did not apply the statute's plain language. Instead, they mined its legislative history--and badly misinterpreted it. They created and applied an "objective test" which found irrelevant any evidence that a peer review action was maliciously motivated, or designed to accomplish ulterior economic goals Congress did not intend to protect. Careful review undresses the basis for this "objective test."

The starting point is the statutory language. 42 U.S.C. § 11112(a)(1) requires a professional review action be "taken in the reasonable belief" that the action furthered quality health care. This standard has both subjective and objective elements. It clearly contemplates analysis of the subjective reason the action was "taken." But it also requires that the reviewer's belief be "reasonable."

The statute presumes peer review meets this reasonableness standard. But it also entitles a physician to rebut the presumption with evidence suggesting that the reviewer did not take action in the "reasonable belief that [its action] was in the furtherance of quality healthcare." The statute's opportunity to rebut the presumption is rendered meaningless, if courts will not consider evidence that a reviewer's action was "taken" to further some other, non-immune, purpose. Such evidence must be relevant.

The so-called "objective test" originated with the decision in *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992). *Austin* interpreted HCQIA's legislative history to mean that a physician's allegations of "animosity," "hostility," or "bad faith" were irrelevant because "the test [for immunity under §11112(a)] is an objective one." *Id.* at 734. Of course, courts should not consult or interpret legislative history when a statute's terms are unambiguous. *Garcia v. United States*, 469 U.S. 70, 76 n.3 (1984). *Austin* did not merely violate this principle. It also flatly misinterpreted the legislative history.

HCQIA's legislative history neither describes nor supports such an "objective test." The history reveals that Congress originally considered a broader immunity than it ultimately created. It considered requiring "good faith" as the test and standard for immunity. H.R. REP. NO. 99-903, at 10 (1986),

reprinted in 1986 U.S.C.C.A.N. 6384, 6392, 1986 WL 31972 (also attached as Appendix I, at 59a to this Petition). But Congress feared that a "good faith" standard might be misinterpreted to require "only a test of the subjective state of mind" of the reviewers. So it chose a more restrictive and "more objective 'reasonable belief' standard." *Id.* Thus, a reviewer could not claim immunity for unreasonable actions simply by arguing they acted in "good faith." This test was a *"more objective"* standard, according to Congress. But it was not the simplistic "objective test" announced in *Austin*. It simply defies common sense to suggest that Congress' restriction of the immunity created an "objective test" that turns a blind eye to malice, bad faith or other unprotected motives.

Further, *Austin* goes beyond merely holding that subjective good faith is not "the test" for immunity. It states that evidence of a reviewer's subjective motive (whether bad faith, malice, or anti-competitive bias) is "irrelevant." The logic is badly flawed. Concluding that "subjective good faith" is "not the test" does not mean that subjective bad faith is "irrelevant." Stated otherwise, proving that a reviewer had a subjective good faith intent may not satisfy or comprise "the test" for HCQIA immunity. But evidence of what actually motivated him must still be relevant to determine whether the reviewer's action was "taken in the reasonable belief that [it] was in the furtherance of quality healthcare." 42 USC § 11112(a).

Despite these fundamental flaws, *Austin*'s "objective test" repeatedly has been followed by federal courts, who typically cite it with virtually no analysis or discussion. See *Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318 (11th Cir. 1994); *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461 (6th Cir. 2003); *Lee v. Trinity Lutheran Hosp.*, 408 F.3d

1064 (8th Cir. 2005); *Braswell v. Haywood Regional Medical Center*, No. 06-1360, slip op., 2007 WL 1227464 (4th Cir. 2007); *Matthews v. Lancaster,* 883 F. Supp 1016 (E.D. Pa. 1995); *Reyes v. Wilson Memorial Hospital,* 102 F.Supp 2d 798 (S.D. Ohio 1998).

State courts have followed suit and now the judicially crafted "objective test" predominates in the case law. See, e.g., *Gateway Cardiology, P.C. v. Wright*, 204 S.W.3d 676 (Mo. App. 2006); *Fox v. Parma Community Hosp.*, 160 Ohio App. 3d 409, 419, 2005-Ohio-1665 (App. 2005). As did Ohio's Seventh District Court of Appeals below, these courts apply the test simply because courts before them have done so. And they cite only the frequency of its application as justification for applying it again.

The Ohio Seventh District Court of Appeals decision in Petitioner's case is especially disconcerting. That court apparently extended the judicially created "objective test" even beyond previously reported lengths. It stated (without any citation to legal authority): "If a hospital rids itself of a doctor both because of health care concerns *and* because of financial/political concerns, HCQIA will give the hospital immunity from suit." *Cowett v. TCH Pediatrics, Inc.*, 7th Dist. No. 05 MA 138, 2006-Ohio-5269, at ¶23 (Ohio App. 2006) (emphasis in original).

This baffling rationale creates a rule acknowledging that a hospital may have both legitimate and "ulterior" (non-immune) motives for peer review discipline. When paired with an objective test that precludes the court from hearing "irrelevant" evidence of the ulterior motive, it permits a court to rule, as a matter of law, that the protected motive predominated over the ulterior one. Thus, a hospital can now somehow act maliciously and reasonably, at the same time--

and be immune from liability, as a matter of law. Congress would be stunned to know that result.

C. Absolute Immunity Harms Quality Health Care

The judicial redrafting of HCQIA immunity threatens the quality of health care. "Sham peer review is rampant. It threatens not only quality care for all of our patients, but the very integrity of the medical profession." See Lawrence R. Huntoon, M.D., Ph.D., *Sham Peer Review and the Courts*, JOURNAL OF AMERICAN PHYSICIANS & SURGEONS, Volume 11, No. 1, Spring 2006, at 4-5, *available at http://www.jpands*.org/vol11no1/huntoon.pdf (last visited May 23, 2007).

When a reputable physician's career is terminated with a sham peer review process, because a hospital seeks to avoid the $400,000 buy-out of his contract, patients have lost. When a whistleblower physician complains about poor medical practices and suffers retaliatory peer review to silence him (and deter others like him), the quality of medical care suffers. Congress' plain words reveal that it could never have intended immunity for such malicious or bad faith peer review.

CONCLUSION

The petition for a writ of certiorari should be granted.

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APPENDIX

APPENDIX A

SUPREME COURT OF OHIO

Case No. 2006-2099

[Filed February 28, 2007]

Richard W. Cowett, M.D.	)
	)
v.	)
	)
TCH Pediatrics, Inc., et al.	)
	)

ENTRY

Upon consideration of the jurisdictional memoranda filed in this case, the Court declines jurisdiction to hear the case.

(Mahoning County Court of Appeals; No. 05MA138)

/s/
THOMAS J. MOYER
Chief Justice

APPENDIX B

STATE OF OHIO, MAHONING COUNTY
IN THE COURT OF APPEALS
SEVENTH DISTRICT

CASE NO. 05 MA 138

[Filed September 27, 2006]

RICHARD W. COWETT, M.D.,)
PLAINTIFF-APPELLANT,)
)
-VS-)
)
TCH PEDIATRICS, INC., et al.,)
DEFENDANTS-APPELLEES.)
)

Civil Appeal from Common Pleas Court,
Case No. 02 CV 3259.

JUDGES: Hon. Mary DeGenaro, Hon. Gene Donofrio,
Hon. Joseph J. Vukovich.

DeGenaro, J.

¶ 1 This timely appeal comes for consideration upon the record in the trial court, the parties' briefs, and their oral arguments before this court. Plaintiff-Appellant, Dr. Richard Cowett, appeals the decision of the Mahoning County Court

of Common Pleas that granted summary judgment to Defendants-Appellees, TCH Pediatrics, Inc., Forum Health, Western Reserve Care System, and Tod's Children's Hospital (collectively referred to herein as Forum). Dr. Cowett claims the trial court erred by not allowing discovery of a letter, by applying an incorrect standard when granting summary judgment, and by concluding that Forum is immune from suit. Dr. Cowett's arguments all stem from his belief that Forum will not be immune from suit if he can show that it acted in bad faith when terminating his staff privileges. However, both state and federal courts unanimously hold that we must look to the objective reasonableness of the hospital's actions, not whether those actions were taken in good faith. For these reasons, the trial court's decision is affirmed.

Facts

¶ 2 Dr. Cowett is a pediatric neonatology specialist who was hired by Forum to be the Director of the Division of Neonatology at Tod's, which placed him in charge of Tod's Special Care Nursery (hereinafter SCN), a neonatal intensive care unit. Dr. Cowett began his duties with Forum on August 1, 2001. When he was hired, Tod's was affiliated with the Rainbow Babies and Children's Hospital in Cleveland, which is operated by the Cleveland-based University Hospitals Health Systems (hereinafter UH). Two of the neonatologists working at Tod's SCN, including Dr. Natalie Yeaney, worked with both UH and Forum. UH did not know of or approve Dr. Cowett's employment until after he was hired by Dr. Robert Felter, the Chairman of Pediatrics & Adolescent Medicine for Western Reserve Care System and Tod's Medical Director and Administrator.

¶ 3 Dr. Cowett was not working at Forum long before staff members began complaining about his abilities. On

September 21, 2001, Dr. Yeaney told Dr. Felter about concerns she had in regard to the care Dr. Cowett provided two infants, Baby F and Baby H. Dr. Felter had a staff board certified neonatologist who had not practiced in the area in a few years, Dr. Kurt Wegner, review the charts for these two patients. After a quick review, Dr. Wegner told Dr. Felter that there was cause to investigate Dr. Cowett further. Dr. Felter also spoke with the Chief Resident, Pediatric Residency Director, and SCN Nursing Manager, all of whom reported that the staff under their management had reported issues with Dr. Cowett's clinical skills.

¶ 4 On October 4, 2001, Dr. Felter was informed about further concerns that Dr. Yeaney and the SCN's nurse-practitioner, Beverly Mike-Nard, had regarding the care Dr. Cowett provided to Baby L. After speaking with Dr. Cowett, who denied that the care he provided was substandard, Dr. Felter placed him on administrative leave pending a formal review into the allegations against him.

¶ 5 Dr. Felter spoke with Dr. Wegner and Forum's Corporate Risk Manager, Michael Keating, who in turn spoke with a variety of people who had knowledge of the situation. However, neither Dr. Wenger nor Keating spoke with Dr. Cowett about the allegations. However, Dr. Wegner later gave Dr. Felter an Executive Summary which criticized the care Dr. Cowett had provided to Babies F, H, and L.

¶ 6 Dr. Felter and Dr. Wegner met with Dr. Cowett on October 15, 2001, to discuss the allegations. Dr. Cowett was given an opportunity to explain his side of the story. After this meeting, Dr. Wegner told Dr. Felter that the interview did not change the thoughts he expressed in his Executive Summary.

¶ 7 The information compiled by Dr. Wegner and Keating was later used as part of a Departmental Peer Review Report which was critical of Dr. Cowett's clinical abilities. Based on the information in this report, Dr. Felter requested that the Vice President of Medical Affairs initiate corrective action against Dr. Cowett. The Profession Executive Committee met on October 23, 2001, to discuss Dr. Felter's request and voted to recommend that Dr. Cowett's staff privileges be revoked. Dr. Cowett was provided notice of this recommendation on October 26, 2001.

¶ 8 Dr. Cowett requested a hearing, which occurred on March 6 and 13, 2002. The hearing was before a three physician panel and twelve witnesses testified. On March 20, 2002, the panel issued an opinion, which concluded that Dr. Cowett had failed to provide appropriate care and recommended that Dr. Cowett's privileges be revoked.

¶ 9 Dr. Cowett appealed this decision to Forum's board of directors, but on June 19, 2002, the Board voted to revoke his privileges. After Forum received a return receipt on the letter advising Dr. Cowett of the Board's decision, it reported the action to the National Practitioner Data Bank, a federal database which tracks hospital discipline of physicians.

¶ 10 On August 16, 2002, Dr. Cowett filed a complaint against Forum, asserting numerous claims resulting from these events. On February 26, 2004, Forum moved for summary judgment, claiming immunity pursuant to 42 U.S.C. 11111, et seq., commonly known as the Health Care Quality Improvement Act (hereinafter HCQIA). Dr. Cowett responded to the motion on January 31, 2005.

¶ 11 On February 3, 2005, Dr. Cowett moved to compel the production of a letter written immediately after his

suspension from a physician at UH to Forum. The trial court ordered that the letter be produced in camera and, on April 4, 2005, denied Dr. Cowett's motion, concluding that the letter's contents were irrelevant and, therefore, not discoverable. The same day it denied Forum's motion for summary judgment and set the matter for trial.

¶ 12 On July 1, 2005, Forum asked the trial court to reconsider its prior order denying summary judgment and Dr. Cowett responded on July 8, 2005. On July 13, 2005, the trial court reconsidered its prior order and entered summary judgment to Forum, concluding that Forum was immune from suit pursuant to HCQIA.

Summary Judgment

¶ 13 On appeal, Dr. Cowett argues three assignments of error, which all address the same issues of law and fact. They are:

¶ 14 "The trial court erred in granting summary judgment, by misconstruing Dr. Cowett's evidence as mere proof of 'animosity,' rather than proof that movants did not satisfy the four requirements for immunity set forth in 42 U.S.C. 11112(a)."

¶ 15 "The trial court erred when it applied a summary judgment standard unsupported by HCQIA and Ohio law."

¶ 16 "The trial court erred in refusing to compel discovery of the UH letter."

¶ 17 Dr. Cowett argues that the trial court erred when granting summary judgment to Forum because the facts, when viewed in the light most favorable to him, show that they

rebut the presumption of qualified immunity for Forum under HCQIA. In particular, he argues that Forum acted in bad faith when initiating and conducting the peer review process. He maintains that the trial court used the wrong standard when ruling on Forum's motion for summary judgment.

¶ 18 The standard a court uses when ruling on a motion for summary judgment on a claim of immunity under HCQIA is "somewhat unusual." *Austin v. McNamara* (C.A.9, 1992), 979 F.2d 728, 734; *Moore v. Rubin,* 11th Dist. No. 2001-T-0150, 2004 Ohio 5013, at ¶ 21; *Menon v. Stouder Mem. Hosp.* (Feb. 21, 1997), 2nd Dist. No. 96-CA-27, 1997 Ohio App. LEXIS 567. Congress has concluded that there is a "need to improve the quality of medical care" and enacted HCQIA "to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. 11101. In order to achieve this goal, HCQIA provides immunity from damages to the "professional review body, * * * any person acting as a member or staff to the body, * * * any person under a contract or other formal agreement with the body, and * * * any person who participates with or assists the body with respect to the action," as long as the professional review meets certain standards. 42 U.S.C. 11111(a)(1).

¶ 19 HCQIA creates a presumption in favor of immunity which may be rebutted by a preponderance of the evidence. 42 U.S.C. 11112(a)(4). It is this rebuttable presumption in favor of immunity which creates the unusual standard courts must use when deciding motions for summary judgment involving HCQIA immunity. *Austin* at 734. In a sense, this means that the plaintiff bears the burden of proving that the peer review process was not reasonable. *Bryan v. James* (C.A.11, 1994), 33 F.3d 1318, 1333. Thus, courts must use the following standard for summary judgment when

determining whether a professional review body is immune from suit under HCQIA: "Might a reasonable jury, viewing the facts in the light best for [the plaintiff], conclude that the plaintiff] has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of 11112(a)?" *Id.*; *Gureasko v. Bethesda Hosp.* (1996), 116 Ohio App. 3d 724, 731, 689 N.E.2d 76; *Moore* at ¶ 21. An appellate court uses this same standard on review and reviews the trial court's decision de novo. *Catipay v. Humility of Mary Health Partners,* 11th Dist. No. 2005-T-0030, 2006 Ohio 1700.

¶ 20 Since we review the issues de novo, Dr. Cowett's second assignment of error is meritless. We will apply the proper standard when reviewing the trial court's decision, so it does not matter whether the trial court applied the proper standard. When a trial court states an erroneous basis for its judgment, we must still affirm that judgment if it is legally correct on other grounds, that is, if it achieves the right result for the wrong reason, because such an error was not prejudicial. *Agricultural Ins. Co. v. Constantine* (1944), 144 Ohio St. 275, 284, 58 N.E.2d 658.

¶ 21 In order to be eligible for immunity under the HCQIA, a professional review action must be taken "1) in the reasonable belief that the action was in the furtherance of quality health care, 2) after a reasonable effort to obtain the facts of the matter, 3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and 4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and [give adequate notice and hearing procedures]." 42 U.S.C. 11112(a).

42 U.S.C. 11112(a)(1)

¶ 22 42 U.S.C. 11112(a)(1) states that a professional review action must be taken "in the reasonable belief that the action was in the furtherance of quality health care." Dr. Cowett contends that any professional review action which is not instigated and carried out in a good faith belief that the action was in the furtherance of quality health care is not entitled to protection under the HCQIA. In support of this argument, he cites both the statutory language and *Ahmed v. University Hospitals Health Care System, Inc.*, 8th Dist. No. 79016, 2002-Ohio-1823. However, these sources do not unambiguously support Dr. Cowett's argument and courts have unanimously disagreed with his argument.

¶ 23 Dr. Cowett contends that evidence of animosity or hostility toward a health care professional is relevant under this statute because it shows that the action was not taken in the furtherance of quality health care. However, the language of the statute would only support Dr. Cowett's arguments if it allowed a defendant to commence a professional peer review action against someone *only* because it believes such action will further quality health care. This is not the language Congress used when it drafted the statute. Instead, HCQIA requires that the defendant must reasonably believe such action will further quality health care. HCQIA allows a hospital to have more than one reason to rid itself of a physician as long as "the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." *Bryan* at 1322. If a hospital rids itself of a doctor both because of health care concerns *and* because of financial/political concerns, HCQIA will give the hospital immunity from suit.

¶ 24 Because a hospital can be immune under HCQIA if it has a reasonable belief that a peer review action was taken in the furtherance of quality health care, even though it had ulterior motives for wanting to be rid of a particular physician, both state and federal courts nationwide have unanimously concluded that evidence of a hospital's bad faith is irrelevant and that courts should use an objective, rather than a subjective, test to determine whether a hospital's belief was reasonable. *See Reyes v. Wilson Mem. Hosp.* (S.D.Ohio, 1998), 102 F.Supp.2d 798, 812 ("Within the universe of published decisions addressing this issue, the courts are unanimous in holding that evidence of 'bad faith' does not suffice to overcome the presumption that a defendant acted 'reasonably.'"). Ohio state courts have been part of the judicial unanimity on this issue. *See Fox v. Parma Community Gen Hosp.*, 160 Ohio App. 3d 409, 2005-Ohio-1665, at ¶ 58, 827 N.E.2d 787; *Moore v. Rubin,* 11th Dist. No. 2001-T-0150, 2004 Ohio 5013, at ¶ 25; *Menon* 1997 Ohio App. LEXIS 567 at *6-7.

¶ 25 The sole case Dr. Cowett relies on, *Ahmed,* did not reach an opposite conclusion. Instead, it held that the evidence supported a jury's verdict that the defendants were not immune and noted, among other evidence, that the hospital had a financial motive for engaging in the peer review proceeding. But while the court's decision certainly indicates the possibility that it would approve using a subjective test, that defendant's motive was not the only evidence supporting the jury's conclusion. Furthermore, the same court later specifically held that a defendant's motive is irrelevant to these issues. *See Fox* at ¶ 58.

¶ 26 At oral argument, Dr. Cowett stated that there is no way to challenge whether a hospital's belief that the action was taken in the furtherance of quality health care is

reasonable if not by showing evidence of bad faith. This is simply not the case. For instance, a physician can challenge the facts forming the basis of a hospital's reasonable belief that the action was not taken in the furtherance of quality health care. In many cases this, of course, will be difficult. But Congress made challenges to HCQIA immunity a difficult prospect so physicians would have "incentive and protection for * * * engaging in effective professional peer review." 42 U.S.C. 11101.

¶ 27 Since any issue of bad faith is irrelevant, Dr. Cowett's arguments concerning the discoverability of a letter from UH to Forum is meritless. The sole reason Dr. Cowett wishes to discover that letter is to further his "bad faith" argument. The trial court did not abused its discretion when denying Dr. Cowett the ability to discover that letter.

¶ 28 When this law is applied to the facts of this case, we conclude the trial court properly granted summary judgment to Forum on the issue of whether the professional review action was taken in the reasonable belief that it was in furtherance of quality health care. The review of Dr. Cowett began after Dr. Yeaney voiced concerns about Dr. Cowett's professional competence to Dr. Felter on September 21, 2001, based on the cases of Baby F and Baby H. On October 4, 2001, Dr. Felter was also informed about concerns in the case of Baby L. These cases raised serious concerns regarding the care Dr. Cowett gave to three babies within the first two months of his employment.

¶ 29 The only evidence Dr. Cowett introduces to rebut the rebuttable presumption that Forum had a reasonable belief that the professional review action was in furtherance of quality health care is his evidence that Forum acted in bad faith. He did not provide any evidence showing that Forum

concerns were unreasonable. Accordingly, the trial court did not err when it concluded that it should grant summary judgment to Forum on this issue. Dr. Cowett's arguments in this regard are meritless.

42 U.S.C. 11112(a)(2)

¶30 Dr. Cowett next contends that Forum did not make a reasonable effort to obtain the facts before taking the professional review action. In particular, he criticized Forum's reliance on Dr. Wegner's opinion, since Dr. Wegner was not an actively practicing neonatologist and had not interviewed Dr. Cowett before preparing his executive summary; its reliance on a peer review report, which he claims contained serious flaws; Forum's failure to have a practicing, board certified neonatologist review the cases and testify at the hearing; and, Dr. Felter's failure to interview the surgeon before recommending the professional review action. Dr. Cowett's arguments in this regard are also meritless.

¶31 HCQIA requires that a defendant make a reasonable effort to obtain the facts of the matter before taking a professional peer review action in order to be immune under the statute. In order to determine whether a defendant made a reasonable effort to obtain the facts of the matter, a court must decide "whether the totality of the process" leading to the professional peer review action "evidenced a reasonable effort to obtain the facts of the matter." *Mathews v. Lancaster Gen. Hosp.* (C.A.3, 1996), 87 F.3d 624, 637. The question of whether a particular professional review action taken against a physician is reasonable is different than whether the action was taken after a reasonable effort to obtain the facts of the matter. *Austin v. McNamara* (9th Cir.1992), 979 F.2d 728, 735.

¶ 32 When reviewing whether the effort to investigate was reasonable, courts have not stated that a reviewing body take any particular action. For instance, courts have refused to require "that only physicians in the same field as the physician under review are qualified to determine whether emergency action is necessary." *Pfenninger v. Exempla, Inc.* (C.Colo.2000), 116 F. Supp. 2d 1184, 1202. Indeed, court have held that those conducting the review do not even need to be physicians. *Meyers v. Logan Mem. Hosp.* (W.D.Kent.2000), 82 F.Supp.2d 707, 713. Furthermore, the ultimate decisionmaker does not need to ensure that a matter is investigated independently, only that the investigation is reasonable. *Gabaldoni v. Washington Co. Hosp. Assoc.* (4th Cir.2001), 250 F.3d 255, 261.

¶ 33 When reviewing whether an investigation was reasonable, courts do not require that such an investigation be accurate and thorough. Accordingly, courts have also overlooked factual errors in prepared reports that were used to reach a professional review action. *See Brader v. Allegheny Gen. Hosp.* (3rd Cir.1999), 167 F.3d 832, 841; *Van v. Anderson* (N.D.Tex.2002), 199 F.Supp.2d 550, 572-573. Likewise, an investigation does not need to conclusively resolve why a particular incident which is the subject of the professional review occurred. *Fox* at ¶ 59. Finally, the HCQIA does not require that a physician be notified of or participate in an investigation being conducted against him. *Catipay v. Trumbull Mem. Hosp.*, 11th Dist. No. 2003-T-0136, 2004-Ohio-5108, at ¶ 44.

¶ 34 In this case, the incidents which formed the basis of the professional review action were reviewed by a board certified neonatologist who was last recertified in neonatology in 1996 and had last practiced in the field in 1997, four years before he was asked to review Cowett's actions. During the

course of the investigation, Dr. Wegner, Dr. Felter, and Forum's corporate risk manager, Michael Keating, spoke to many hospital personnel about Dr. Cowett's practical skills. Finally, the issues were fully heard by a three member panel of the Professional Staff. Dr. Cowett's arguments do not rebut the presumption that this was a reasonable effort to obtain the facts. Instead, Dr. Cowett merely shows that the investigation was not as comprehensive and independent as he would have liked. The HCQIA does not require a comprehensive, independent investigation, only a reasonable effort to obtain the facts. Dr. Cowett's arguments in this regard are meritless.

42 U.S.C. 11112(a)(3)

¶ 35 Dr. Cowett also argues that Forum did not provide him with adequate notice and hearing procedures. As an example, he cites the fact that the hearing panel issued its decision before the date by which he was told to submit a written statement. He also contends that he did not have notice of the true reasons behind the peer review action. Dr. Cowett's arguments in this regard are also meritless.

¶ 36 A professional review action is not immune under HCQIA unless it is taken "after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances." 42 U.S.C. 11112(a)(3). 42 U.S.C. 11112(b) "enumerates the minimum, or 'safe harbor' procedures that will, in every case, satisfy the adequate notice and hearing requirements" of 42 U.S.C. 11112(a)(3). *Bryan* at 1323. However, the safe harbor provision also provides that '[a] professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section." 42 U.S.C. 11112(b). Furthermore, there is no

requirement that "makes immunity depend on adherence to bylaws." *Wieters v. Roper Hosp., Inc.* (4th Cir.2003), 58 Fed.Appx. 40, 46. "The ultimate inquiry is whether the notice and hearing procedures were adequate." *Smith v. Ricks* (9th Cir.1994), 31 F.3d 1478, 1486. The peer review proceedings need not resemble a regular trial to meet this requirement. *Id.* at 1487.

¶ 37 In this case, Dr. Cowett's only complaint about the notice given him is that it was not true notice of the reasons for the professional review action. However, he is merely re-raising the issue of whether Forum acted in bad faith when taking the professional review action. Since bad faith is not a proper issue to address when determining immunity under HCQIA, this is not a proper basis to challenge the notice given to him.

¶ 38 Dr. Cowett also complains that he was not provided adequate hearing procedures since he was not allowed to submit a written post-hearing statement to the hearing panel before it rendered its decision. He contends that 42 U.S.C. 11112(b) "statutorily entitled" him to submit such a statement.

¶ 39 Although 42 U.S.C. 11112(b)(3)(C)(v) does state that a physician must be given the right to "to submit a written statement at the close of the hearing" in order to meet the "safe harbor" standards set forth in 42 U.S.C. 11112(b), 42 U.S.C. 11112(b) itself states that hearing procedures are not inadequate merely because they do not meet the conditions in that subsection. For example, 42 U.S.C. 11112(b)(1)(B)(ii) states that a physician should be afforded thirty days within which to request a hearing. However, a hospital can still provide adequate procedures if it only gives a physician fourteen days to request a hearing, depending on the facts of

the case. *See Egan v. Athol Mem. Hosp.* (D.Mass. 1997), 971 F.Supp. 37, 43-44.

¶ 40 In this case, Dr. Cowett's sole complaint is that he was not given the opportunity to provide the hearing panel with a written statement before it issued its recommendation. However, the hearing panel was not the ultimate decisionmaker in this case. After it made its recommendation, Dr. Cowett was given the opportunity to provide the Board with a written statement explaining the purported flaws in the hearing panel's opinion and Dr. Cowett submitted such a statement. Thus, Dr. Cowett was given an opportunity to place his arguments in the record before the Board made its decision, which is the purpose behind the requirement in 42 U.S.C. 11112(b)(3)(c)(v).

¶ 41 Based on these facts, the trial court did not err when it found that no reasonable fact-finder could conclude that the notice and hearing procedures provided to Dr. Cowett were inadequate. Dr. Cowett's arguments to the contrary are meritless.

42 U.S.C. 11112(a)(4)

¶ 42 HCQIA's final requirement is that the professional review action be taken "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)." 42 U.S.C. 11112(a)(4). When making this determination courts are "not to substitute our judgment for that of the hospital's governing board or to reweigh the evidence regarding the renewal or termination of medical staff privileges." *Shahawy v. Harrison* (11th Cir.1989), 875 F.2d 1529, 1533. The relevant inquiry is whether the decision was

reasonable in light of the facts known at the time the decision was made, not in light of facts later discovered. *Egan* at 44.

¶ 43 In this case, the record shows that Cowett failed to demonstrate that the Board's belief that the facts warranted the professional review action taken against Dr. Cowett was unreasonable. Fundamentally, the Board had two sets of facts before it. One set of facts contained the conclusions of two staff neonatologists, a nurse practitioner, experienced nurses, and hearsay evidence from residents who worked with Dr. Cowett, which all questioned Dr. Cowett's clinical abilities and the decisions he made in the cases in question. Another set of facts contained the testimony of Dr. Cowett, his expert witness, and other experienced nurses, which supported both Dr. Cowett's professional competence and the decisions he made in the cases in question. After reviewing these facts and the recommendations given to it, no reasonable factfinder could conclude that the Board's decision was unreasonable. Dr. Cowett's arguments to the contrary are meritless.

Conclusion

¶ 44 Dr. Cowett believes Forum should not be immune from suit pursuant to HCQIA because it acted in bad faith when determining that his privileges should be revoked. However, the only relevant issues under HCQIA are with regard to the objective reasonableness of the hospital's actions, not whether those actions were taken in good faith. No reasonable fact-finder could conclude that Dr. Cowett could overcome the presumption that Forum's actions were reasonable. Accordingly, the judgment of the trial court is affirmed.

Donofrio, P.J., concurs.
Vukovich, J., concurs.

APPROVED

/s/
MARY DeGENARO, JUDGE.

APPENDIX C

IN THE COURT OF COMMON PLEAS
MAHONING COUNTY, OHIO

CASE NO. 02 CV 3259

[Filed July 13, 2005]

RICHARD M. COWETT, M.D.)
)
Plaintiff)
)
vs.)
)
T C H PEDIATRICS, INC., et al.)
)
Defendant)

JUDGMENT ENTRY

This matter came before the Court on Defendant's Motion for Reconsideration denying Summary Judgment and requesting a ruling on the issue of HCQIA immunity. Plaintiff filed a Memorandum of Law in Response. First, the Court will address Plaintiff's argument that this Court should not rule on Defendant's Motion for Reconsideration since no new evidence or theory was presented to the Court. This argument is not well taken. An order overruling a motion for summary judgment is subject to revision at any time prior to the

entering of a final judgment. Moreover, the Court does not need to have new theories presented to it, but rather may proceed based upon the same law and facts.

The facts of this case have been outlined and briefed extensively in numerous pleadings, They can be summarized as follows. Plaintiff, Richard M. Cowett M.D. was hired as Director of Neonatology for Tod Children's Hospital. His employment was suspended and then terminated after peer review proceedings at the hospital. Plaintiff claims that his employment was terminated for non-medical reasons. He alleges that his termination was done to pacify Defendants business partners at University Hospital Health System ("University Hospital") in Cleveland, Ohio. The Defendants have denied these allegations and claim that the peer review process was accomplished appropriately and for good cause.

The Health Care Quality Improvement Act ("HCQIA") was enacted by congress to promote effective peer review nationwide and to protect parties involved in the peer review process. A professional review action must be taken: "(1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of Paragraph (3)" *Fox v. Parma Community General Hospital et al.*(2005) 160 Ohio App.3d 409, 416. Furthermore, 42U.S.C. Sec. 11112(a) states "A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111 (a) of this title unless

the presumption is rebutted by a preponderance of the evidence."

Usually, the party moving for Summary Judgment bears the burden to prove that there are no genuine issues of material fact and that the movant is entitled to judgment as a matter of law. However, because of the presumption contained in HCQIA, Ohio courts have adopted the following standard: "might a reasonable jury, viewing the facts in the best light for [plaintiff]conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of §11112(a)?" *Fox supra* at 418 citing *Austin v. McNamara* (C.A.9, 1992) 979 F.2d 728,738. It should be noted that when this Court overruled Defendants' Motion for Summary Judgment, this Court did not apply the foregoing standard but rather looked to determine if a genuine issue of material fact existed.

To rebut the presumption, Dr. Cowett points to the difficult relationship between Tod Children's Hospital and University Hospitals at the time. Plaintiff alleges that his hiring by Dr. Felter of Tod Children's Hosptal was not in accordance with the wishes and desires of Dr. Avner of University Hospital and as a result, he was terminated after two months of services. Plaintiff further relies upon the fact that Tod Children's Hospital ran an advertisement for a new director prior to Dr. Cowett's evidentiary hearing. Dr. Cowett also raises several issues regarding the investigation and peer review process and flaws in the bylaw procedure.

Although there may have been some animosity toward the hiring of Dr. Cowett, case law prohibits the court to consider the subjective state of mind or good faith of the reviewers. *Menon M.D. v. Stouder Memorial Hospital et al.* 1997 Ohio App. Lexis 567, (Ohio App. 2nd Dist.) p. 6. The Court must

apply an objective test to determine if the professional review actions were taken in the reasonable belief that they were in the furtherance of quality health care. *Moore v. Rubin* 2004 WL2803237 (Ohio App. 11 Dist.) p. 5. In this matter, concerns about Dr. Cowett's work were raised in September 2001. The matter was addressed in accordance with Defendants' bylaws.

After reviewing all of the facts outlined in the numerous pleadings and applying the requisite standards to this case, this Court cannot find that Dr. Cowett has set forth sufficient evidence from which a jury could conclude that he has overcome the statutory presumption by a preponderance of the evidence.

Based on the foregoing, this Court will reconsider its prior ruling on Defendants' Motion for Summary Judgment. It is hereby ordered, decreed and adjudged that Defendants' Motion for Summary Judgment be sustained.

This is a final appealable order.

7/13/05

Hon:/s/
MAUREEN A. SWEENEY

APPENDIX D

IN THE COURT OF COMMON PLEAS
MAHONING COUNTY OHIO

CASE NO. 02 CV 3259

[Filed April 4, 2005]

RICHARD M. COWETT, MD.	)
	)
Plaintiff	)
	)
vs.	)
	)
T C H PEDIATRICS, INC., et al,	)
	)
Defendant	)
	)

JUDGMENT ENTRY

This matter came before the Court on Defendant's Motion for Summary Judgment, Plaintiff's Brief in Opposition and Defendant's Reply. Oral Arguments were held and the Court took the matter under advisement.

The issue before the Court is whether Defendant's are entitled to immunity under O.R.C. 2305.251 and Health Care Quality Improvement Act ("HCQIA"). Contrary to Defendants' argument, Plaintiff's allege that the immunity is

"qualified" and that the facts represent, when construed in Plaintiff's favor, show immunity is not appropriate in this case.

Ohio revised code section 2305.251 provides for qualified immunity. This immunity may be overcome by clear and convincing evidence of actual malice. Actual malice may not be inferred from evidence of personal spite, ill-will or intention to injure on the part. Rather, it must be a showing that false statements were made with reckless disregard as to their truth or falsity. *Lonsdale v. Academy of Medicine of Cleveland* (Dec. 10, 1992), 8th Dist. No. 61405. Furthermore, *Ahmed v, University Hospitals Health Care Systems, Inc.* (April 18, 2002) 8th Dist. No 79016, the Court found that the provisions of the statute must be construed under a good faith standard, This court finds that there is a genuine issue of material fact as to whether not the defendants acted in good faith during their investigation and the revocation proceedings.

The Health Care Quality Improvement Act requires that when revoking a doctor's privileges, the committee must act reasonableness during all proceedings and provide the affected party and adequate notice. The concept of reasonableness, in this matter, is at issue. Given the evidence presented in Plaintiff's brief and in oral arguments, and construing the same in the light most favorable to Plaintiff, this court finds that there is an issue as to reasonableness which must be decided by the trier of fact. Summary Judgment for the defendant is not appropriate at this time.

Based on the foregoing, defendant's motion for summary judgment is overruled.

This matter is currently set for jury trial beginning May 23, 2005 at 10:00 a.m.

3/30/05	/s/
DATE	HON. MAUREEN A. SWEENEY

APPENDIX E

42 U.S.C.A. § 11101

UNITED STATES CODE ANNOTATED

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 117—ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

§ 11101. Findings

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

APPENDIX F

42 U.S.C.A. §11111

UNITED STATES CODE ANNOTATED

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 117—ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

SUBCHAPTER I—PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

§ 11111. Professional review

(a) In general

(1) Limitation on damages for professional review actions

If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b)—

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, *42 U.S.C. 2000e*, et seq. and the Civil Rights Acts, 42 U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 15c of Title 15, where such an action is otherwise authorized.

(2) Protection for those providing information to professional review bodies

Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

(b) Exception

If the Secretary has reason to believe that a health care entity has failed to report information in accordance with section 11133(a) of this title, the Secretary shall conduct an investigation. If, after providing notice of

noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a health care entity has failed substantially to report information in accordance with section 11133(a) of this title, the Secretary shall publish the name of the entity in the Federal Register. The protections of subsection (a)(1) of this section shall not apply to an entity the name of which is published in the Federal Register under the previous sentence with respect to professional review actions of the entity commenced during the 3-year period beginning 30 days after the date of publication of the name.

(c) Treatment under State laws

(1) Professional review actions taken on or after October 14, 1989.

Except as provided in paragraph (2), subsection (a) of this section shall apply to State laws in a State only for professional review actions commenced on or after October 14, 1989.

(2) Exceptions.

(A) State early opt-in.

Subsection (a) of this section shall apply to State laws in a State for actions commenced before October 14, 1989, if the State by legislation elects such treatment.

(B) Effective date of election.

An election under State law is not effective, for purposes of [1], for actions commenced before the effective date of the State law, which may not be earlier than the date of the enactment of that law.

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[1] So in original. Probably should be "for purposes of subparagraph (A)"

APPENDIX G

42 U.S.C.A. § 11112

UNITED STATES CODE ANNOTATED

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 117—ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

SUBCHAPTER I—PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

§ 11112. Standards for professional review actions

(a) In general

For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken—

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate notice and hearing

A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating—

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B)—

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right—

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right—

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.

(c) Adequate procedures in investigations or health emergencies

For purposes of section 11111(a) of this title, nothing in this section shall be construed as—

(1) requiring the procedures referred to in subsection (a)(3) of this section—

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

APPENDIX H

42 U.S.C.A. § 11151

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 117—ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

SUBCHAPTER III—DEFINITIONS AND REPORTS

§ 11151. Definitions

In this chapter:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

(2) The term "Board of Medical Examiners" includes a body comparable to such a Board (as determined by the State) with responsibility for the licensing of physicians and also includes a subdivision of such a Board or body.

(3) The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity.

(4)(A) The term "health care entity" means—

(i) a hospital that is licensed to provide health care services by the State in which it is located,

(ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary), and

(iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary).

(B) The term "health care entity" does not include a professional society (or committee thereof) if, within the previous 5 years, the society has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.

(5) The term "hospital" means an entity described in paragraphs (1) and (7) of section 1395x(e) of this title.

(6) The terms "licensed health care practitioner" and "practitioner" mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.

(7) The term "medical malpractice action or claim" means a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.

(8) The term "physician" means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on—

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

(10) The term "professional review activity" means an activity of a health care entity with respect to an individual physician—

(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,

(B) to determine the scope or conditions of such privileges or membership, or

(C) to change or modify such privileges or membership.

(11) The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review

activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

(12) The term "Secretary" means the Secretary of Health and Human Services.

(13) The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(14) The term "State licensing board" means, with respect to a physician or health care provider in a State, the agency of the State which is primarily responsible for the licensing of the physician or provider to furnish health care services.

APPENDIX I

H.R. REP. 99-903
1986 U.S.C.C.A.N. 6384

****6384** P.L. 99-660, HEALTH PROGRAMS
DATES OF CONSIDERATION AND PASSAGE
Senate August 12, October 18, 1986
House October 17, 1986

Senate Report (Labor and Human Resources Committee)
No. 99-380, Aug. 6, 1986 [To accompany S. 1744]
Cong. Record Vol. 132 (1986)
Related Reports:
Senate Report (Labor and Human Resources Committee)
No. 99-225, Dec. 18, 1985 [To accompany S. 1848]
Senate Report (Governmental Affairs Committee)
No. 99-506,Sept. 30, 1986 [To accompany S. 1209]
House Report (Energy and Commerce Committee)
No. 99-908, Sept. 26, 1986 [To accompany H.R. 5546]
House Report (Energy and Commerce Committee)
No. 99-903, Sept. 26, 1986 [To accompany H.R. 5540]
House Report (Energy and Commerce Committee)
No. 99-154, June 3, 1986 [To accompany H.R. 2417]
Senate Report (Labor and Human Resources Committee)
No. 99-229, Jan. 22, 1986 [To accompany S. 1762]
Much of Title IV of this Public Law was derived from
H.R. 5540. House Report (Energy and Commerce
Committee) No. 99-903, Sept. 26, 1986
[to accompany H.R. 5540] is set out:

HOUSE REPORT NO. 99-903
September 26, 1986

*1 The Committee on Energy and Commerce, to whom was referred the bill (H.R. 5540) to encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

*2 PURPOSE AND SUMMARY

The purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.

Under this bill, hospitals and physicians that conduct peer review will be protected from damages in suits by physicians who lose their hospital privileges, provided the peer review actions meet the due process and other standards established in the bill. In addition, hospitals and physicians that discipline doctors will be required to report these disciplinary actions to the state medical boards. In turn, the state medical boards will be required to forward this information to the Secretary of the Department of Health and Human Services ('the Secretary') or the Secretary's designee. The bill further requires hospitals to seek this information from the Secretary, or the Secretary's designee, before hiring doctors or other licensed health care practitioners.

The bill also requires paid malpractice claims to be reported to the Secretary, or the Secretary's designee.

BACKGROUND AND NEED FOR THE LEGISLATION

The Committee has reviewed testimony from numerous sources indicating that this legislation is essential to protect the public health and safety.

This bill is needed to deal with one important aspect of the medical malpractice problem in this country — incompetent and unprofessional physicians. It does not address the malpractice insurance crisis, which has extremely complex and controversial origins and cannot be solved through peer review. The bill's focus is on those instances in which physicians injure patients through incompetent or unprofessional service, are identified as incompetent or unprofessional by their medical colleagues, but are dealt with in a way that allows them to continue to injure patients.

**6385 Unfortunately, groups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent or unprofessional doctors often do not do so. Even when such bodies do act against bad physicians, these physicians find it all to easy to move to different hospitals or states and continue their practices in these new locations.

The result has been a series of highly visible situations in which physicians with a long history of incompetence or unprofessional conduct have continued to cause needless deaths and injury for years after their damaging behavior was noticed. This legislation would do much to reduce the damage committed by this small, but very destructive, group of doctors. It would require organizations that discipline doctors to report their disciplinary actions to a central location and

would require hospitals to seek this information before hiring doctors. It would also require the reporting and dissemination of paid malpractice claims.

To assure that the medical profession cooperates in this system, the Committee believes it is essential to provide some legal immunity to doctors and hospitals that engage in peer review activities. as noted above, under current law and practice, physicians who *3 engage in incompetent or unprofessional acts find it very convenient to move to another jurisdiction and resume practice. There are two reasons for this. One is that hospitals too often accept 'voluntary' resignations of incompetent doctors in return for the hospital's silence about the reasons for the resignations. Hospitals make these agreements in order to avoid lengthy and unpredictable litigation. The other is that there is no comprehensive national reporting system to follow bad doctors from place to place.

The reporting system in this legislation would virtually end the ability of incompetent doctors to skip from one jurisdiction to another. The reporting system, however, creates a major problem. Many people in the medical field told the Subcommittee on Health and the Environment that the reporting system would inevitably result in an enormous increase in litigation. The reason: faced with the certainty that they can no longer hide their past records, physicians facing disciplinary action will feel compelled to challenge vigorously any action taken against them. Based on recent experience, the Committee believes that many of these physicians will file antitrust lawsuits.

Even though defendants may often win these lawsuits, that may not be sufficient to guarantee enthusiastic, or even minimally adequate, peer review. Unlike other activities that may trigger antitrust lawsuits, properly limited peer review

plays no essential or important economic role in the practice of medicine. Doctors who are suffiently fearful of the threat of litigation will simply not do meaningful peer review. The result would be to continue the possibilities for abuse by bad doctors.

Thus, there is a clear need to do something to provide protection for doctors engaging in peer review if this reporting system is to be workable. To that end, the bill provides limited, but essential, immunity. Doctors and hospitals who have acted in accordance with the reasonable belief, due process, and other requirements of the bill are protected from damages sought by a disciplined doctor. The **6386 bill protects innocent and often helpless consumers from abuses by bad doctors without insulating improper anticompetitive behavior from redress.

HEARINGS

The Committee's Subcommittee on Health and the Environment held one day of hearings on H.R. 5110 (and the related bill, h.R. 4390) on July 15, 1986. Testimony was received from 12 witnesses, representing 11 organizations. One witness was a medical director who had hired numerous physicians without being able to discover even well documented problems—sometimes with tragic consequences. Other witnesses represented hospital associations, medical professional groups, the Inspector General of the Department of Health and Human Services, large employers, the Federation of State Medical Boards, and the U.S. General Accounting Office.

COMMITTEE CONSIDERATION

On September 17, 1986, the Subcommittee on Health and the Environment met in open session and considered the bill H.R. 5110. The bill was ordered reported as amended, to be introduced as a *4 clean bill, by a voice vote, a quorum being present. On September 18, 1986, the Committee met in open session and ordered reported the clean bill H.R. 5540, without amendment by voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the bill will have a negligible budget effect for fiscal year 1987 and thereafter because of savings that should result from implementing the reporting system. In the short term, savings would be expected from reductions in the volume of payments under federal programs for unnecessary care or care that is delivered incompetently and results in the need for additional services. In the longer term, savings would also be expected

to result from relatively lower hospital expenses for liability insurance.

U.S. CONGRESS,

CONGRESSIONAL BUDGET OFFICE,

Washington, DC, September 22, 1986.

**6387 Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 5540, the Health Care Quality Improvement Act of 1986, as ordered reported by the Committee on Energy and Commerce on September 18, 1986. The bill would encourage hospitals, insurance companies, and other health care entities to report information concerning medical malpractice payments, sanctions for professional incompetence or misconduct, and other professional review actions taken against health care providers. In exchange for reporting, this bill would grant immunity under federal law to hospitals and individuals.

H.R. 5540 would establish a health care provider information clearinghouse to collect and disseminate the reported information on health care providers. The clearinghouse would be run by the Secretary of Health and Human Services (HHS) or, at the Secretary's discretion, by an appropriate public or private agency. If the clearinghouse is run by HHS, CBO estimates that enactment of this bill could result in costs to the federal government of $30 million in fiscal year 1987 and $10 million in each fiscal year thereafter. If however, the Secretary exercises his discretion to appoint

a *5 private agency to operate the clearinghouse system, the cost to the federal government could be insignificant.

Hospitals would be required to request information from the clearinghouse prior to hiring any licensed health care professional applicant. Also, at least every two years each hospital would be required to request information on each member of its medical staff. All of the costs associated with information reported would be borne by private hospitals, insurance companies, boards of medical examiners, and other health care entities.

Both the Federation of State Medical Boards (FSMB) and the American Medical Association (AMA) maintain data bases containing information similar to that required under the bill. The data collection activities described in this bill would be much more extensive than any that currently exist. Based on rough estimates provided by the AMA, this bill could require approximately one million hospital staff member credential checks per year. In fiscal year 1987, it could cost about $30 million to create the comprehensive data base, to operate the system, and to respond to credential check inquiries. For each fiscal year thereafter, the federal government could expect a cost of about $10 million to maintain and operate the system. These rough estimates relfect the costs of operating a clearinghouse for information only on physicians. Additional costs could be expected since the bill requires the data base to include information on all licensed health care professional, not just physicians.

**6388 Please call me or have your staff contact Marianne Deignan (226- 2820) if you have further questions.

With best wishes,

Sincerely,

EDWARD GRAMLICH

(For Rudolph G. Penner, Director).

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill:

The Committee reports that enactment of this measure will not have an inflationary impact on the economy. The bill is intended to improve public health and safety by reducing the number of injuries and deaths associated with incompetent or unprofessional medical care by physicians. By reducing the costs associated with incompetent and unprofessional physicians, the bill is likely to have a favorable effect with respect to inflation.

SECTION-BY-SECTION ANALYSIS

Section 1

Short Title and Table of Contents.

*6 Title I--Promotion of professional review activities

Section 101

Precludes damages, against professional review bodies and persons taking professional review actions that meet the standards defined in section 102.

Provides immunity for persons providing information to professional review bodies without knowledge that the information is false.

Suspends protection against damages if health care entity does not comply with reporting requirements of section 203.

Section 102

For a professional review action to qualify for protection from damages it must be taken:

In the reasonable belief that it is in furtherance of qualify care;

After a reasonable effort to obtain facts;
After adequate due process;
In the reasonable belief that the action was warranted by facts known.

Characteristics of due process that would be deemed adequate:

Notice of action, with reasons specified;
Right to hearing with notice of time, place, date, and witnesses to testify;
Hearing held before arbitrator or hearing officer or panel not in direct economic competition with physician involved;

**6389 Right to representation, to copies of the record, to call and examine witnesses, to present evidence, and submit written statement;
Right to receive written recommendation and decision.

Due process can be different in health emergencies or under other applicable law.

Section 103

Court permitted to award attorneys' fees to defendant who prevails and whose professional review action met standards of this bill.

Court may not award attorneys' fees to plaintiff unless it determines that it would be appropriate to do so.

Section 104

Secretary of the Department of Health and Human Services may establish voluntary guidelines to assist professional review bodies in meeting standards.

Section 105

Activities not covered by this legislation remain under current law, including activities regarding nurses or other practitioners who are not physicians.

Bill creates no requirement that health care entities grant clinical privileges to any or all health care practitioners.

*7 Section 106

Bill applies to actions commenced on or after effective date.

Title II--Reporting of Information

Section 201

Information on paid malpractice claims must be reported to Secretary or designee.

Civil monetary penalties provided for failure to report. Secretary to study need to report on small payments and also on all claims made.

Section 202

Boards of Medical Examiners must report to Secretary when physician licenses are revoked, suspended, or other actions are taken for reasons relating to competence or professional conduct, or when licenses are surrendered.

Sanction for failure to report is loss of designation under Section 203.

Section 203

Health care entities that take actions adversely affecting clinical privileges for 30 days, that accept privileges during or to avoid an investigation, or that take actions adversely affecting professional society membership, must report information on such actions to the Board of Medical Examiners in that state.

**6390 Health care entities permitted to report similar actions respecting practitioners who are not physicians.

Boards of Medical Examiners must in turn report such information to the Secretary or designee.

Section 204

Reporting must be not less often than monthly and in form and manner prescribed by Secretary.

Secretary of the Department of Health and Human Services may designate an appropriate private or public agency for receipt of required reports.

Malpractice information reported to Secretary must also be reported to appropriate state Board.

Section 205

Hospitals required to request information reported to Secretary or designee when physician or other practitioner applies to be on staff, and biennially thereafter.

Sanction for failure to report is that hospital is presumed to have such information in a medical malpractice action.

Hospitals relying on such information not known to be false are protected.

Section 206

Secretary must provide for disclosure of information to affected practitioner, and for procedures in case of disputed accuracy.

*8 Section 207

Secretary authorized to provide information to other health care entities and to State boards, upon request.

Information reported to Secretary is considered confidential, except with respect to professional review activity, medical malpractice actions, or other specifically authorized disclosures.

Civil monetary penalties for violations of confidentiality.

Persons reporting information protected in absence of knowledge that information was false.

Payments of malpractice claims not to be construed as creating presumption that malpractice has occurred.

Title III--Definitions and reports

Section 301

Various definitions.

Professional review action not considered to be based on 'competence or professional conduct' if it is based on:

> Relationship with professional society or association;
> Advertising, charging lower fees, or engaging in other competitive acts;
> Financial arrangement for delivering health care;
> Relationship with practitioners who are not physicians.

Professional societies not eligible for protections if they have been found to have engaged in anti-competitive practices

restricting the practice of other practitioners within previous 5 years.

**6391 Section 302

Secretary to report annually for three years on implementation of this legislation.

Secretary of the Department of Health and Human Services to seek to enter into memoranda of understanding with Secretary of Defense and Administrator of Veterans Affairs to apply provisions of legislation to facilities and personnel under their jurisdiction.

Secretary of the Department of Health and Human Services to seek to enter into memorandum of understanding with Administrator of Drug Enforcement Administration concerning revocations of registration to dispense controlled substances.

DISCUSSION: COMMITTEE VIEWS

Title I--Promotion of professional review activities

Section 101. Professional Review

Subsection (a) provides limited, but essential, protection from liability for persons conducting professional review actions based on the competence or professional conduct of individual physicians. To qualify for the protection, the professional review action must meet the standards specified in section 102(a) and must be an action as defined in section 301(9). If those criteria are met, the persons engaging in or assisting in the conduct of professional review action shall not be liable in damages with respect to the action.

The Committee feels that the purposes of this bill require protection for persons engaging in professional review. Under current *9 state law, most professional review activities are protected by immunity and confidentiality provisions. A small but growing number of recent federal anti-trust actions, however, have been used to override those protections. Because the reporting system required under this legislation will most likely increase the volume of such suits, the Committee feels that some immunity for the peer review process is necessary.

Initially, the Committee considered establishing a very broad protection from suit for professional review actions. In response to concerns that such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls, however, the Committee restricted the broad protection. As redrafted, the bill now provides protection only from damages in private actions, and only for proper peer review, as defined in the bill. The bill leaves completely intact the jurisdiction of the Federal Trade Commission, the Justice Department, and State Attorneys General to bring antitrust actions. In addition, the bill does not restrict the rights of physicians who are disciplined to bring private causes of action for injunctive or declaratory relief. If the professional review actions being challenged fail to meet the standards of section 102(a), no immunity is provided and the suit can be tried without regard to the provisions of this bill.

Subsection (a) also provides immunity for persons providing information to professional review bodies, unless the information is false and the person providing the information actually knows it is false. The Committee intended to encourage persons to report information **6392 regarding possible incompetence or unprofessional behavior

on the part of physicians. Such persons might have no connection with a professional review body, and thus the Committee determined that such immunity would not be made contingent on the propriety of the actions of the professional review body.

Subsection (b) bars immunity for health care entities that do not participate fully in the reporting requirements of section 203(a). The approach used in this legislation reflects the Committee's strong feeling that the current problem of incompetent or unprofessional physicians being able to disappear and leave their history behind must end. This problem can be solved only if hospitals and other health care entities make their findings available to each other through the reporting systems established in this legislation.

Simply conducting professional review to rid a single hospital or a single community of a problem physician without reporting the action is not sufficient to warrant the protection provided under this legislation. Accordingly, health care entities that do not report do not get immunity under this bill. This does not mean that minor or technical flaws in reporting will trigger the loss of immunity. To protect health care entities in this regard, the Secretary is required to follow specified procedures prior to suspending or disqualifying them from the immunity provisions.

The fact that a professional review action was or was not taken against a physician under this bill shall in no way affect the right of a patient to file a malpractice claim or action for damages. Nor shall such failure affect any defenses to such a malpractice action. For example, a patient might seek to include a hospital in a malpractice action where the hospital has information related to the ***10** professional conduct or competence of a physician, takes a professional review action

that meets the standards of this bill, exonerates the physician, and the patient is subsequently injured by the physician. Although the hospital and the professional review body would not be subject to damages in a suit by the physician, this immunity would not apply to any suit by the patient.

Although the Secretary is required to work with health care entities to bring them into compliance, the Secretary is also obligated to act should the Secretary suspect that these entities are out of compliance. The bill requires the Secretary to conduct an investigation whenever the Secretary has reason to believe that a health care entity has failed to report appropriately. Thus, if professional reviewers or even members of the general public notify the Secretary that a hospital is out of compliance, the Secretary will be required to conduct an investigation.

Section 102. Standards for professional review actions

Subsection (a) establishes the standards that a professional review action must meet in order to qualify for immunity under section 101. The first requirement is that the action be taken in the reasonable belief that it is in the furtherance of quality health care. Initially, the Committee considered a 'good faith' standard for professional review actions. In response to concerns that 'good faith' might be misinterpreted as requiring only a test of the subjective state of mind of the physicians conducting the professional **6393 review action, the Committee changed to a more objective 'reasonable belief' standard. The Committee intends that this test will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.

Reflecting the Committee's belief that this standard will be met in the overwhelming majority of professional review actions, the subsection provides a presumption to that effect, requiring a plaintiff to show, by clear and convincing evidence, that no such reasonable belief existed at the time of the professional review action. This presumption applies only to the reasonable belief standard, not to the other standards. Those additional standards require a group engaged in peer review to make a reasonable effort to obtain the facts, to provide adequate due process, and to have a reasonable belief that the professional review action was warranted by the facts known.

The due process requirement can always be met by the procedures specified in subsection (b). If the procedures specified in that subsection are provided, the health care entity will be deemed to have met the due process standard. If other procedures are followed, but are not precisely of the character spelled out in subsection 102(b), the test of 'adequacy may still be met under other prevailing law. The Committee is aware, for example, that some courts have already carefully spelled out different requirements for certain professional review activities or actions, such as procedures for decisions regarding applicants for clinical privileges at a hospital. In those situations, compliance with applicable law should satisfy the 'adequacy' requirement even where such activities or actions *11 require different or fewer due process rights than the ones specified under subsection 102(b). In any case, it is the Committee's intent that physicians receive fair and unbiased review to protect their reputations and medical practices.

The Committee intends that the hearing panel or officer be impartial and fair in evaluating a physician's behavior. In order to ensure that reviews of physicians pertain only to

quality of care, the Committee has specified that members of the hearing panel, or the hearing officer, cannot be in direct economic competition with the physician-respondent. The Committee recognizes that in many cases, such as small hospitals or group practices, hospitals or physicians in rural areas, or situations involving highly specialized work, this requirement may present some difficulty. In particular, it may not be feasible to find physicians who are of the same specialty as the respondent but who are not in direct in economic competition. Nevertheless, the Committee expects the professional review body to make every reasonable effort to find appropriate officers or members of the panel, even if this requires bringing in reviewers from out of town or using physicians of a different specialty.

The Committee also notes that the failure to meet the standards of subsection 102(a) creates no presumption with respect to the liability or lack of liability of a health care entity. Such failure would, therefore, be inadmissible in evidence in any litigation between **6394 a physician and any person or group engaged in peer review. The only conclusion that follows from a failure to meet those standards is that the entity is not entitled to the immunity conferred under this legislation. The entity is still entitled to the full range of defenses and immunities available under other applicable law and practice.

One of the requirements of due process is notice. The Committee is aware that between the time the initial notice is given of a proposed professional review action and the time of the hearing on that action, the investigation may have uncovered reasons for such an action other than or in addition to the reasons specified in the initial notice. Provided that notice is given in a way that protects the interests of the physicians against whom the action is proposed, a

supplemental notice of such additional reasons might well satisfy the requirements of due process.

Subsection (c) modifies the due process required to obtain immunity under section 101(a) during investigations or in health emergencies. Under this provision, there is no requirement that due process meet a test of 'adequacy' where no adverse professional review action is taken (e.g., an investigation resulting in a decision not to take a professional review action), or during a suspension or restriction of clinical privileges for a period not longer than 14 days during an investigation to determine the need for a professional review action. In addition, due process can be provided after the fact where clinical privileges are suspended or restricted on an immediate basis where the failure to take such an action might result in an imminent danger to the health of an individual.

The Committee felt strongly that it was necessary to establish these exceptions to provide for appropriate protection during investigations and to allow quick action where it would be reasonable to *12 conclude that someone's health might otherwise suffer. Nevertheless, these exceptions are not meant to provide a back door for harassment of physicians through repeated short-term suspensions or interminable investigations never leading to a professional review action. Such actions could not meet the 'reasonable belief' test in subsection 101(a). Health care entities should bring a full-fledged professional review action where such instances repeatedly recur with regard to a specific physician.

The Committee intends that these provisions allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible. The provisions would allow a court to make a determination that the defendant has

or has not met the standards specified in section 102(a). The Committee intends that the court could so rule even though other issues in the case remain to be resolved. For example, a court might determine at an early stage of litigation that the defendant has met the 102(a) standards, even though the plaintiff might be able to demonstrate that the professional review action was otherwise improper. At that point, it would be in order for the court to rule on immunity. In such a case, the court could still proceed to determine whether injunctive, declaratory, or other relief would be in order.

**6395 Section 103. Payment of reasonable attorneys' fees and costs in defense of suit

This section sets forth the provisions adopted by the Committee on Energy and Commerce concerning attorneys' fees.

Section 104. Guidelines of the Secretary

To assist the professional review bodies in meeting the standards of section 102(a), the Committee has authorized the Secretary of the Department of Health and Human Services to issue voluntary guidelines. The Committee intends that these guidelines be nonbinding, and should leave ample room for health care entities to tailor their procedures to their individual situations. While procedures that follow the guidelines should meet the requirements of section 102(a), there should be no presumption that procedures that do not specifically follow such guidelines do not meet those requirements.

Section 105. Construction

Subsection (a) clarifies that where or to the extent that this legislation does not apply, all other applicable law does apply. For example, in an antitrust action, the substantive tests remain those of the antitrust laws. Where the standards of this legislation are met, however, such a suit shall not result in any liability for damages. As another example, the due process requirements of section 102 apply only where immunity is claimed for a professional review action; where no immunity is sought, other applicable law determines the extent to which due process is required with regard to an action by a health care entity.

Subsection (b) reflects the intention of the Committee not to affect in any way the rights of individuals to apply for clinical privileges with health care entities, and the rights of health care entities to accept or deny those applications. This legislation only *13 defines the basis upon which immunity from damages will be granted with regard to professional review actions; where no immunity is claimed under this legislation, no standards regarding professional review actions are established by this legislation.

Subsection (c) further clarifies the previous subsections to incorporate the Committee's intention that this legislation shall have no effect regarding professional review actions with respect to health care professionals who are not physicians. Applications for clinical privileges and disciplinary actions against such professionals shall be judged solely according to other applicable law without regard to this legislation.

Title II. Reporting of information

Section 201. Requiring reports on medical malpractice payments

Subsection (a) sets forth the requirement that each entity (including an insurance company) which makes a payment under a policy of insurance, under a self-insurance arrangement, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment **6396 in, a medical malpractice action or claim shall report the payment and the circumstances respecting the payment to the Secretary or the Secretary's designee.

This subsection does not require double reporting. Only the entity actually making the payment is required to report. On the other hand, if several physicians or health care practitioners, or their insurers, make payments with respect to the same incident involving a patient, each payer must submit a report.

Although malpractice data must be viewed with some caution, the Committee believes that it is essential to collect and disseminate these data to those in the health care community who make judgments about the competence and professional conduct of health care practitioners. Unfortunately, to date, neither state disciplinary boards not the peer review system has adequately identified those incompetent or unprofessional practitioners from whom the public must be protected. With all of it faults, the malpractice system has been the primary approach that aggrieved patients have taken to deal with inadequate medical care. Accordingly, malpractice data can provide important clues for evaluating the credentials of health care practitioners.

In making this point, the Committee is well aware that malpractice data provide only clues, not conclusions. Any number of considerations other than the merits of a claim can affect the size and frequency of malpractice payments. The sympathy generated by the severity of an injury, the attractiveness of a claimant, the skill of a claimant's attorney, the demands of a busy medical practice and the unpredictability of juries can all lead health care practitioners to settle cases or lose verdicts with respect to medical services that meet or exceed accepted standards of medical care. Furthermore, even a legitimate malpractice claim does not automatically mean that a practitioner deserves disciplinary action. Any practitioner—even the most skilled and careful—can make an occasional mistake.

*14 Notwithstanding these limitations on the validity of malpractice data, the Committee believes that, on balance, they will prove to be extremely useful. The Committee is confident that those authorized under this bill to gain access to this information will have the awareness and sensitivity to use it responsibly.

Subsection (b) sets forth the information to be reported under subsection (a). This subsection does not necessarily require extensive descriptions of the acts or omissions nor of the injuries or illnesses upon which the action or claim was based. It does, however, require sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action or claim.

In the same vein, subsection (b)(5) authorizes the Secretary to determine that certain other information is necessary in order to interpret information reported under this section. For example, when several health care practitioners are involved in one incident, as opposed to separate incidents,

it would be important to identify that group of claims as one incident. The Secretary may determine that a particular format for reporting such cases is necessary to link them to a single incident. Similarly, the Secretary might determine **6397 that to avoid the substantial confusion likely to arise regarding the identity of physicians or health care practitioners involved in malpractice payments because of the similarity of physicians' or practitioners' names, additional identifying information is needed to avoid mistaken listings.

Subsection (c) responds to the concerns of those who question the wisdom of requiring information on all malpractice payments. Many observers believe that most small payments arise only with respect to 'nuisance' claims, i.e., those claims that have little merit but which can be resolved so cheaply that it makes sense to settle rather than litigate them. Upon reflection, the Committee has decided not to except small claims because of the difficulty of choosing an appropriate cutoff point and because of the Committee's feeling that a significant number of small payments may, notwithstanding the sums involved, represent truly meritorious claims. For example, an extremely incompetent physician in a particular specialty might rarely face claims involving sums greater than a few thousand dollars. Without the reporting of all claims, such a practitioner might never be identified. Accordingly, the Committee believes that the law should be comprehensive with respect to reporting. Nevertheless, the Committee believes that it would be useful to have the Secretary evaluate the information reported under the bill and determine whether the number of meritless small claims is so great that any benefits derived from reporting all claims are vastly outweighed by the resources required to process small claims.

This subsection also requires the Secretary to address the information reported under the bill from a different perspective. Some observers have suggested that information regarding malpractice payments is not timely enough to enable truly effective peer review. They suggest that a better approach would be to require reports whenever a malpractice claim is made, rather than when it is paid. Accordingly, the bill directs the Secretary to evaluate and report on this possible approach as well.

*15 Section 203. Reporting of certain professional review actions taken by health care entities

Subsection (a) requires health care entities that take professional review actions that adversely affect the clinical privileges of a physician for a period greater than 30 days to report information regarding such action to the appropriate Board of Medical Examiners in accordance with section 204(a) of the bill. It also requires a health care entity that accepts the surrender of a physician's clinical privileges in return for the entity not conducting an investigation or commencing a proceeding to make such reports.

The purpose of requiring reports even for circumstances in which physicians surrender their privileges is to ensure that health care entities will not resort to 'plea bargains' in which a physician agrees to such a surrender in return for the health care entity's promise not to inform other health care entities about the circumstances of the physician's surrender of privileges. While such agreements may serve the immediate self interests of the two parties involved, **6398 they may jeopardize the health and safety of future patients likely to seek treatment for the physician. As detailed in subsection (c)(1), health care entities that fail to meet these requirements

face the loss of the protection set forth in section 101 of this bill.

Subsection (a)(1)(C) makes clear that the same rules apply with respect to an entity which is a professional society when it takes a professional review action that adversely affects the membership of a physician in the society.

Subsection (a)(2) authorizes a health care entity to report to the Board of Medical Examiners disciplinary actions regarding, or surrenders of, clinical privileges of licensed health care practitioners who are not physicians. Although the Committee encourages health care entities to make such reports, it does not require them because the protection set forth in section 101 of this bill do not apply with respect to such activities in the case of nonphysicians. As noted elsewhere in this report, the fact that the bill's protections do not apply should in no way be interpreted as indicating a belief on the part of the Committee that health care entities should refrain from disciplining incompetent or unprofessional nonphysician practitioners. To the contrary, the Committee would applaud such disciplining and urges health care entities that do so to report to the Board of Medical Examiners in accordance with this subsection.

Subsection (a)(3) sets forth the information to be reported by health care entities. It does not necessarily require an extensive description of the acts or omissions or other reasons for the action or, if known, for the surrender. It does, however, require sufficient specificity to enable a knowledgeable observer to determine clearly the circumstances of the action or surrender. The subsection further authorizes the Secretary to require such other information respecting the circumstances of an action or surrender as the Secretary deems appropriate. This would also

authorize the Secretary to establish general requirements with respect to such information should the Secretary deem them appropriate.

*16 Subsection (b) requires Boards of Medical Examiners to report, in accordance with section 204, the information reported under subsection (a). It further requires these boards to report all instances known to them of a health care entity's failure to report information under subsection (a)(1). The Committee has imposed this requirement because it believes that Boards of Medical Examiners are uniquely situated to acquire information about the failure of a health care entity to comply with subsection (a)(1). For example, the Secretary or the Secretary's designee might not notice the fact that a large hospital in a state engaged in a practice of 'plea bargaining' with physicians it felt to be incompetent. On the other hand, the state board, because of its general knowledge of hospital practices in the state, might well realize that the hospital was in noncompliance. Although the bill imposes no obligation on the state board to investigate hospitals about which it has insufficient knowledge, it does require the board to report where it does have adequate knowledge.

**6399 As previously discussed, subsection (c) makes clear that a health care entity that fails substantially to meet the requirement of subsection (a)(1) shall be suspended from the protections of section 101(a)(1), as provided in section 101(b). Similarly, if the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (b), this subsection requires the Secretary to designate another qualified entity for the reporting of information under subsection (b). The Secretary has the same discretion with regard to designating another entity as the Secretary does with respect to designating an appropriate private or public agency to receive information as

set forth in section 204(b). The Secretary may choose any appropriate private or public agency so long as such agency will comply with necessary safeguards and will carry out its responsibilities under the supervision of the Secretary and the terms of this bill.

Section 204. Form of reporting

Subsection 204(a) requires that information required to be reported under sections 201 (relating to medical malpractice payments), 202(a) (relating to actions taken by state boards of medical examiners) and 203 (relating to actions taken by health care entities) be reported at least once a month to the Secretary (or the Secretary's designee) in such form and manner as the Secretary prescribes. The Committee notes that no report is necessary when there is nothing to report. Information may not be required to be reported until the Secretary specifies a beginning date, which must occur no later than one year after the date of enactment. The purpose for this beginning date is to permit the Secretary (or the Secretary's designee) some time to design and develop the reporting system.

Subsection (b) makes clear that the Secretary may operate the reporting system or may, in the Secretary's discretion, authorize an appropriate private or public agency, which has made suitable arrangements with the Secretary with respect to receipt, storage, protection or confidentiality, and dissemination of information, to operate the reporting system. Although the Secretary may authorize another agency to operate the reporting system, the Secretary may not delegate the Secretary's authority to anyone outside of the Department *17 of Health and Human Services under subsections 201(b)(5), 202(a)(2)(C), 203(a)(3)(C), or any other section relating to the setting of substantive reporting requirements.

If the Secretary determines that part, rather than all, of the reporting system should be delegated to an agency outside of the Department of Health and Human Services, the Secretary may do so. Similarly, the Secretary may delegate parts of the reporting system among several agencies. Such decisions fall completely within the Secretary's discretion.

Because the decision to delegate is entirely discretionary with the Secretary, the decision to withdraw a delegation is also entirely discretionary. Absent any contractual obligation, the Secretary may withdraw delegation of authority to a public or private agency at any time and for any reason.

The Committee is aware that most state medical boards currently transmit information similar to that called for in this bill to a **6400 central clearinghouse known as the Federation of State Medical Boards of the United States. Should the Secretary decide to delegate some or all of the Secretary's authority to operate the reporting system to an outside agency, the Committee would encourage the Secretary to consider this organization among any other applicants for the delegation of authority. The Committee notes, however, that this legislation was made necessary by the fact that none of the private sector efforts to date adequately dealt with collecting and disseminating the required information. Accordingly, the Secretary must look carefully not only to the technical capacity of any organization seeking to be the Secretary's designee for reporting, but also to the organization's historical policies and practices, if such exist, with regard to collecting and disseminating information on incompetent or unprofessional physicians.

Subsection (c) requires malpractice payments reported under section 201 to be reported to the appropriate state licensing board or boards in the state in which the medical

malpractice claim arose. In the case of a physician, the reports generally would be sent to the state board of medical examiners. In the case of a nonphysician practitioner, the reports would be sent to whichever state licensing board issues the license for, or authorizes the practice of, the practitioner. For purposes of this subsection, the state in which a medical malpractice claim arose is the state in which the medical treatment giving rise to the claim was administered.

Subsection (c)(2) requires information reported under section 203(b) also to be reported to the appropriate state licensing board in the state in which the health care entity is located if it is not otherwise reported to such board under subsection (b). This provision is necessary because health care entities are required (under section 203(a)) to report only to their state boards of medical examiners which, in turn, are obligated (under sections 203(b) and 204(b)) to report to the Secretary or the Secretarys designee. In at least two instances this reporting system would not reach the appropriate state licensing board: (i) in the case of a non-physician practitioner regulated by a state licensing board other than the board of medical examiners and (ii) in the case where the Secretary has designated, pursuant to subsection 203(d), an entity other than the board of medical examiners, to substitute for the state board of *18 medical examiners. Accordingly, this subsection makes clear that reports concerning non-physician practitioners sent by health care entities to the state board of medical examiners should be passed along to any other appropriate state licensing board, and any reports to a substitute entity should be forwarded to the board of medical examiners itself.

The Committee notes that some boards of medical examiners are required to investigate every complaint against

a physician. The question has arisen whether the extensive amount of new information required would unduly burden such boards, given their investigative requirements. The Committee feels that the response by boards may vary in different circumstances. It might be appropriate for boards to establish screening criteria for certain types of information, such as very low malpractice payments or minor restrictions of privileges. But the Committee also notes that the purpose **6401 of this bill is to improve the identification and disciplining of physicians who are incompetent or engage in unprofessional behavior, and that this may well require additional efforts on the part of some boards.

Section 205. Duty of hospitals to obtain information

Subsection 205(a) imposes a special obligation upon hospitals (as defined in section 301(5)). Although section 207 gives specified persons and organizations access upon request to the information reported under this Act, it does not require them to seek this information. The Committee believes that it would be prudent for all health care entities authorized to request such information to do so on a regular basis, and it strongly encourages them to do so. Subsection 205, however, establishes a duty for hospitals to request the information. The Committee believes this to be appropriate given the central role that hospitals play in the nation's health care system. It is in hospitals that the most serious medical cases are cared for and the most sophisticated and hazardous treatments are provided. Most peer review occurs in the hospital setting. For most physicians and licensed health care practitioners, perhaps the most severe disciplinary action next to the loss of their license is the loss of clinical privileges at a hospital. Accordingly, it is esential that hospitals be as well informed about the competence and professional conduct of their medical staff as possible.

Hospitals are required to request information when physicians apply for privileges and every two years thereafter. The Committee notes that the biennial request generally will be for information on the entire hospital staff, all at once. The hospital is not expected to file separate requests on the biennial anniversaries of the applications of each individual for staff privileges.

Subsection (b) establishes a presumption with respect to a medical malpractice action against a hospital that the hospital had any information reported to the Secretary or the Secretary's designee which the hospital should have requested pursuant to subsection (a). The fact that the presumption has arisen under this section does not automatically mean that the hospital has committed medical malpractice. But, it does mean that the hospital should be held to the standard of care to which any person in possession of this information would have been held.

***19** The presumption applies in all instances in which the hospital fails to request the information when required to do so. Thus, a court would act properly in barring any evidence offered by a hospital in a malpractice action to show that practical or logistical difficulties within the Department of Health and Human Services would ahve prevented the hospital from obtaining the information even if the hospital had requested it. On the other hand, where the hospital has requested the information, the presumption shall not apply where the hospital never receives the information because of shortcomings on the part of the Department of Health and Human Services. Similarly, the presumption shall arise only in those instances in which the hospital is obligated—as opposed to authorized—to request the information.

**6402 Subsection (c) provides that hospitals may rely on information provided to them pursuant to the bill and shall not be held liable for such reliance in the absence of the hospital's actual knowledge that the information provided was false. This principle obviously also would apply in section 207 to any person authorized to request such information.

Section 206. Disclosure and correction of information

Section 206 requires the Secretary, by regulation, to provide: (i) disclosure of the information reported under this bill respecting a physician or other licensed health care practitioner upon request by the physician or practitioner and (ii) procedures in the case of disputed accuracy of the information.

The Committee realizes that storing and processing large quantities of data occasionally may lead to errors by the Secretary (or the Secretary's designee). In order to minimize the possibility that such errors may unfairly stigmatize someone, the bill requires the Secretary to disclose, upon request, information about a physician or practitioner to such physician or practitioner. In cases in which the physician or practitioner disputes the accuracy of the information, the Secretary is obligated to have procedures for addressing such disputes. This requirement does not mean that the Secretary is generally required to conduct an investigation to determine the accuracy of the information. In most cases, any dispute should be resolved between the person who reported the information and the one who challenges its accuracy. In those instances in which the affected parties are unable to resolve a disagreement about the information, the Secretary would discharge the Secretary's obligations under this section simply by noting that a dispute exists about the accuracy of the information and including a brief statement by the physician

or practitioner setting forth the disagreement regarding the information. Nothing in this section is intended to require the Secretary to include points of disagreement submitted by a physician or practitioner regarding information in the Secretary's files where the Secretary has concluded that the information is accurate.

Section 207. Miscellaneous provisions

Subsection 207(a) requires the Secretary (or the Secretary's designee) to provide information reported under this title, upon request, with respect to a physician or other licensed health care practitioner ***20** to state licensing boards, hospitals and other health care entities (including health maintenance organizations) that have entered (or may be entering) into an employment of affiliation relationship with the physician or practitioner or to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff. As noted above, the Committee strongly encourages all of these entities that are authorized to request this information to do so on a regular basis. While there is no formal requirement in this legislation that these entites request this information, the Committee expects them to do so as part of their responsibility to improve the quality of care. Moreover, the Committee notes that routine requests would seem to be the prudent ****6403** course, since such entities clearly have an obligation to protect their enrollees from incompetent practitioners and could face potential liability in medical malpractice claims for not seeking such information. Subsection 207(b)(3) specifies that such information is intended to be used solely with respect to activities in the furtherance of health care by the person requesting the information, subject to the provisions of 207(b)(1).

Subsection 207(b) sets forth the confidentiality requirements with respect to information reported under this title. Such information shall not be disclosed (other than to the physician or practitioner) except with respect to professional review activity, with respect to medical malpractice actions, or in accordance with regulations of the Secretary promulgated pursuant to subsection (a). This subsection also makes clear that any party, such as a state licensing board, which is authorized under other provisions of law to release such information, may continue to release it.

Title III--Definitions and reports

Section 301. Definitions

Subsections (4)(A)(ii) and (iii) include as health care entities those entities providing health care services and those professional societies that follow formal peer review processes for furthering quality health care. The Secretary of the Department of Health and Human Services is required to determine, by regulation, whether a formal peer review process meets the test of being for the purpose of furthering quality health care. Hospitals, which are defined as health care entities under subsection (4)(A)(i), are subject to extensive similar provisions for purposes of accreditation, and thus are not subject to Secretarial review under this subsection.

Subsection (4)(B) excludes from the definition of a health care entity, and thus from the protections conferred under this legislation, a professional society that has been found to have engaged in anti-competitive practices that restricted the practice of licensed health care practitioners within the previous five years. The Committee encourages bona fide professional review actions by professional societies.

However, the Committee is concerned about instances in which professional societies have abused their peer review activities unlawfully to restrict the practices of health care professionals who are not physicians. To guard against conferring immunity inappropriately in such circumstances, and to provide a *21 disincentive for future anti-competitive practices, the Committee has adopted this restriction.

Subsection (9) defines 'professional review actions.' Only actions that meet this definition are eligible to confer immunity under this legislation. The definition includes circumstances in which a professional review body exonerates a physician, or otherwise formally decides not to take a professional review action. It also includes all professional review activities, such as a period of investigation, related to a professional review action.

The Committee has specified that the only professional review actions that are contemplated as eligible for immunity under this **6404 legislation are those based on the competence or professional conduct of an individual physician. Thus, actions against a class of physicians do not fall within the purview of this legislation. For example, hospitals may routinely require that physicians have a specific type or level of specialty training to qualify for certain hospital privileges. Depending on the circumstances, such rules may or may not be for the purpose of furthering the quality of health care, and they may or may not be lawful. This legislation does not apply with respect to such practices, which shall continue to be judged under applicable law.

Actions against practitioners who are not physicians also are under the purview of this legislation. In addition, the Committee has carefully delineated circumstances which would not be considered to be based on competence or

professional conduct. These include actions based on one's joining or not joining a professional society; on one's fees; on advertising or otherwise lawfully competing for business; on the economic organizations of one's practice; or on one's activities with regard to health care practitioners who are not physicians. These exclusions are not in any way meant to deter legitimate professional review actions against physicians or other health care practitioners. The Committee is well aware that incompetent or unprofessional behavior will occur with regard to health care practitioners who are not physicians, just as it will with physicians. Such behavior should be subjected to appropriate professional review actions. But the Committee heard concerns from several groups that this area presented the greatest potential for abuse of the professional review process for economic or other reasons under the guise of improving the quality of health care. Accordingly, the Committee chose to restrict the protections under this legislation to actions by physicians against other physicians who do not meet reasonable tests of competence or professional behavior. Professional review actions against physicians for reasons excluded from this legislation or those against other health care practitioners shall continue to be judged under all applicable law.

Section 302. Reports and memoranda of understanding

Subsection (a) requires annual reports to the Congress by the Secretary of the Department of Health and Human Services on the implementation of this Act. This reflects the Committee's intention that the Secretary move quickly to establish the reporting system and to encourage professional review actions. The Committee has determined that physicians who are judged to be incompetent or to have engaged in unprofessional behavior must be identified immediately *22 to protect the public. The Committee intends to review these

annual reports carefully in considering the need for any additional legislation to protect the public through effective peer review. Subsection (b) directs the Secretary of the Department of Health and Human Services to enter into a memoranda of understanding with the Secretary of Defense and the Administrator of Veterans' Affairs to apply the reporting requirements of this legislation to the health care facilities under their jurisdiction. The Committee is aware that the problems this legislation is intended to address are **6405 not unique to civilian health care. Accordingly, the Secretary of the Department of Health and Human Services should make available to these other agencies the expertise and resources applied and developed in implementing this Act. The Committee does not intend to create incentives for physicians identified and traced under this legislation to disappear into the Defense Department or the Bureau of Veterans' Affairs, or vice-versa.

AGENCY VIEWS

No views on this legislation were received from the Department of Health and Human Services.

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COMMITTEE VIEWS ON H.R. 5540

The Committee on Energy and Commerce is aware that the Committee on the Judiciary has requested a sequential referral of the bill after it is reported by the Committee. Should any provisions of this bill be modified before passage by the House of Representatives, the Committee on Energy and Commerce will submit for the Record additional comments explaining those changes.

H.R. REP. 99-903, H.R. Rep. No. 903, 99TH Cong., 2ND Sess. 1986, 1986 U.S.C.C.A.N. 6384, 1986 WL 31972 (Leg.Hist.)